



Orthotic Department -825 Old Lancaster Rd., Suite 200, Bryn Mawr, PA 19010
800-321-9999

PATIENT DELIVERY FORM

Patient Name: Eglebon Sereno Date of Birth: [REDACTED]

Account Number: [REDACTED]

Orthotic device dispensed  REF 11-0666-2

Right / Left Left

L-Code: [REDACTED]

DRYTEX, PLAYMAKER, WRAP, S

Disclaimer:

I have received treatment and / or device from The Rothman Institute. I accept this treatment and / or device knowing that I may be personally and fully responsible for any payment, including out of pocket, deductible and non-payment from my insurance. I understand that while I may be provided an estimate of my financial responsibility, the actual amount due may differ and I will be held liable for any difference. I understand that prior authorization from my insurance is not a guarantee of payment. Medicare patients - I have received the Medicare Supplier Standards.

I understand my physician prescribed this device, and I accept this treatment protocol.

Return Policy: Products may be returned if under warranty and are considered a covered repair. Excessive wear, neglect or abuse of a product will not be covered by the manufacturer. Returns are not accepted on custom fabricated devices. Returns are not accepted on any item after seven days of receipt.

X Patient's Signature: Eglebon Sereno X Date: 10/23/18

Reason for Appointment:

<input type="checkbox"/>	Measurement
<input type="checkbox"/>	Delivery
<input type="checkbox"/>	Follow-up

Date of onset: _____

Billing: _____

Insurance Co: Aetna

Effective Date: _____

Patient Education:

<input type="checkbox"/>	Verbal
<input type="checkbox"/>	Product inserts / Vendor Warranty

Eligibility Contact: _____

Deductible: \$3,000

Deductible Met: Y N

Customization of Orthosis

<input type="checkbox"/>	Trimmed
<input type="checkbox"/>	Bent or molded to patient
<input type="checkbox"/>	Assembled to patient

Copay/Coins.: 10%

Out of Pocket: \$8,000

OOP Met: Y N

Goals:

<input type="checkbox"/>	ADL's
<input type="checkbox"/>	Immobilization
<input type="checkbox"/>	Return to activity

Precert Req: Y / N

Auth #: _____

Patient's Estimated Responsibility:

Amount Pd: _____

Balance: \$776.40

☐ I have checked the prescribed orthosis for quality and appropriateness for my patient.

Practitioner's signature: Daria Furber Printed name: DARIA FURBER

MEDICAL BILL

PO BOX 757910
 PHILADELPHIA, PA 19175-7910
 For billing questions, call (267) 339-3558
 Office Phone (267) 339-3558

ACCOUNT NAME Esteban Serrano
 ACCOUNT NO. [REDACTED]
 STATEMENT DATE 11/28/2018
 INSURANCE PENDING \$0.00

Total Amount Owed: \$829.41

Pay or Inquire about your bill at www.rothmanortho.com. Phone hours: Mon through Thurs 9am - 4pm, Friday 9am - 12pm.

Patient Name Esteban Serrano
 Provider Gattone, Jennifer
 Voucher [REDACTED]

Date	Service Details	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
10/23/18	Knee Ortho Adj Jnt Pos (L1833)	\$882.00			\$882.00
11/09/18	Aetna Payment			\$0.00	\$882.00
11/09/18	Aetna Adjustment			-\$52.59	\$829.41
11/09/18	Aetna Transfer				\$829.41

This amount represents your deductible. Please remit payment.

Visit Total \$829.41

Payment Options

☒ **Mail**
 Please use pay stub below

☐ **Online**
www.rothmanortho.com

Message

Your prompt payment is greatly appreciated.

You may receive multiple statements due to a transition in billing systems.

TO ENSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

658871A (PC2)



ADDRESS SERVICE REQUESTED

10046416.col 1008 10046416
 Stat Date: 11/28/2018

☐ Check box and see reverse for change of address/insurance information.

ESTEBAN SERRANO

Due Date	Account Number	Amount Due	Amount Paid
12/28/2018	[REDACTED]	\$829.41	
IF PAYING BY CREDIT CARD, PLEASE CHECK BOX FOR SELECTION AND FILL OUT BELOW.			
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> VISA	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> AMERICAN EXPRESS
CARD NUMBER		VERIFICATION #	
CARDHOLDER NAME		EXP. DATE	
SIGNATURE			
Or pay online: www.rothmanortho.com			

MAKE CHECKS PAYABLE TO:

THE ROTHMAN INSTITUTE
 PO BOX 757910
 PHILADELPHIA, PA 19175-7910

*PAID
 Jan 25, 2019*

000005934-A



Aetna Life Insurance Company
PO BOX 14079
LEXINGTON KY 40512-4079
*027071*J280EVBA*071015*

Statement date: November 24, 2018

*****SCH 5-DIGIT 19460
12174 1 AV 0.378 52
ESTEBAN E SERRANO

QUESTIONS? Contact us at aetna.com
1-855-521-6853
Or write to the address shown above.

Explanation of Benefits (EOB) - This is not a bill

This statement is called your EOB. It shows how much you may owe, the amount that was billed, and your member rate. It also shows the amount you saved and what your plan paid. Look at this statement carefully and make sure it is correct. If you do owe anything, you will receive a bill from your doctor or health care provider(s). If you have access to the secure member website, you can change your delivery preference, view, print or download your EOBs online anytime.

Track your health care costs

You saved \$1,669.00 by going to a doctor or hospital in the network. That's because we have arranged discounted rates with these providers. The online provider directory can help you find a doctor or other health care professional. Just go to www.aetna.com.

A guide to key terms

Term	This means	Your totals
Amount billed:	The amount your provider charged for services.	\$2,094.00
Member rate:	This is the health plan covered amount which may reflect a health plan discount. This may be referred to as the allowed amount or negotiated rate.	\$425.00
Pending or not payable:	Charges that are either not covered or need more review by us. Read 'Your Claim Remarks' to learn more.	\$0.00
Deductible:	The amount you pay for covered services before your plan starts to pay.	\$425.00
Coinsurance:	When you pay part of the bill and we pay part of the bill. This is the out-of-pocket amount that you may owe.	\$0.00
Copay:	A fixed dollar amount you pay when you visit a doctor or other health care provider.	\$0.00
Other health plan:	This is known as coordination of benefits (COB). When a member has more than one health plan, both plans' payments will not be more than the billed amount. See 'Your claims up close' for other plan details.	

Go Green!

Go to your secure member website and turn off your paper EOBs. You'll see them quicker. And thanks, if you're already doing your part to go green!

Your payment summary

Patient	Provider	Your plan paid			You owe or already paid
		Amount	Sent to	Send date	Amount
Esteban (self)	Oaks Radiology	\$0.00			\$425.00
Total:		\$0.00			\$425.00

ROTHMAN
ORTHOPAEDIC INSTITUTE

PO BOX 757910
PHILADELPHIA, PA 19175-7910

For billing questions, call (267) 339-3558
Office Phone (267) 339-3558

MEDICAL BILL

ACCOUNT NAME Esteban Serrano
ACCOUNT NO. [REDACTED]
STATEMENT DATE 10/29/2018
INSURANCE PENDING \$0.00

Total Amount Owed: \$1,197.00

Pay or Inquire about your bill at www.rothmanortho.com. Phone hours: Mon through Thurs 9am - 4pm, Friday 9am - 12pm

Patient Name

Voucher

Esteban Serrano

Date	Service Details	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
10/23/18	Office Outpatient New 3 (99203)	\$210.00			\$210.00
10/23/18	Radiologic Exam Knee Co (73564)	\$105.00			\$315.00
Visit Total					\$315.00

Patient Name

Voucher

Esteban Serrano

Date	Service Details	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
10/23/18	Knee Ortho Adj Jnt Pos (L1833)	\$882.00			\$882.00

Payment Options

Message

☒ **Mail** Please use pay stub below
☐ **Online** www.rothmanortho.com

Your prompt payment is greatly appreciated.

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TO ENSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

058871A(PC2)

ROTHMAN
ORTHOPAEDIC INSTITUTE

PO Box 757910
Philadelphia, PA 19175-7910
PERSONAL & CONFIDENTIAL

ADDRESS SERVICE REQUESTED

10046416.001 1008 10046416
Stmt Date: 10/29/2018

☐ Check box and see reverse for change of address/insurance information.

ESTEBAN SERRANO

Due Date	Account Number	Amount Due	Amount Paid
11/28/2018	[REDACTED]	\$1,197.00	
IF PAYING BY CREDIT CARD, PLEASE CHECK BOX FOR SELECTION AND FILL OUT BELOW.			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARD NUMBER		VERIFICATION #	
CARDHOLDER NAME		EXP. DATE	
SIGNATURE			
Or pay online: www.rothmanortho.com			

MAKE CHECKS PAYABLE TO:

THE ROTHMAN INSTITUTE
PO BOX 757910
PHILADELPHIA, PA 19175-7910

Billing Details



CONTINUED

Patient Name Provider Voucher
 Esteban Serrano Emper, William [REDACTED]

Date	Service Details	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
10/23/18	Office Outpatient New 3 (99203)	\$210.00			\$210.00
10/23/18	Radiologic Exam Knee Co (73564)	\$105.00			\$315.00
11/09/18	Aetna Payment			\$0.00	\$315.00
11/09/18	Aetna Adjustment			-\$120.10	\$194.90
11/09/18	Aetna Transfer				\$194.90
11/21/18	Self Pay Credit Card Pa			-\$194.90	\$0.00

This amount represents your deductible. Please remit payment.

Visit Total \$0.00

Total Amount Due: \$829.41

NEED TO UPDATE YOUR INFORMATION? FILL OUT THE INFORMATION BELOW:

YOUR NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ MARITAL STATUS ☐ SEPARATED
☐ SINGLE ☐ DIVORCED
☐ MARRIED ☐ WIDOWED

YOUR EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE _____ EFF. DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

POLICY HOLDER'S ID # _____ GROUP PLAN # _____

SECONDARY INSURANCE _____ EFF. DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

POLICY HOLDER'S ID # _____ GROUP PLAN # _____